Senate File 334

S-3087

Amend Senate File 334 as follows:

1. Page 1, before line 1 by inserting:

<DIVISION I

PUBLIC ASSISTANCE PROGRAM ACCOUNTABILITY —— ELIGIBILITY VERIFICATION AND MONITORING>

2. Page 5, line 5, after <this> by inserting <division of this>

3. Page 5, line 11, after <this> by inserting <division of this>

4. Page 5, line 23, by striking <the Act> and inserting <this division of this Act>

5. Page 5, by striking line 28 and inserting <this division of this Act.>

6. Page 5, line 30, after <this> by inserting <division of this>

7. Page 5, line 33, after <this> by inserting <division of this>

8. Page 5, after line 35 by inserting:

<DIVISION ___

PUBLIC ASSISTANCE PROGRAM ACCOUNTABILITY —— MEDICAID MANAGED CARE EXTERNAL REVIEW

Sec. ___. MEDICAID MANAGED CARE ORGANIZATION APPEALS PROCESS —— EXTERNAL REVIEW.

1. a. A Medicaid managed care organization under contract with the state shall include in any written response to a Medicaid provider under contract with the managed care organization that reflects a final adverse determination of the managed care organization's internal appeal process relative to an appeal filed by the Medicaid provider, all of the following:

(1) A statement that the Medicaid provider's internal appeal rights within the managed care organization have been exhausted.

(2) A statement that the Medicaid provider is entitled to an external independent third-party review pursuant to this section.

(3) The requirements for requesting an external independent third-party review.

b. If a managed care organization's written response does not comply with the requirements of paragraph "a", the managed care organization shall pay to the affected Medicaid provider a penalty not to exceed one thousand dollars.

2. a. A Medicaid provider who has been denied the provision of a service to a Medicaid member or a claim for reimbursement for a service rendered to a Medicaid member, and who has exhausted the internal appeals process of a managed care organization, shall be entitled to an external independent third-party review of the managed care organization's final adverse determination.

b. To request an external independent third-party review of a final adverse determination by a managed care organization, an aggrieved Medicaid provider shall submit a written request for such review to the managed care organization within sixty calendar days of receiving the final adverse determination.

c. A Medicaid provider's request for such review shall include all of the following:

(1) Identification of each specific issue and dispute directly related to the final adverse determination issued by the managed care organization.

(2) A statement of the basis upon which the Medicaid provider believes the managed care organization's determination to be erroneous.

(3) The Medicaid provider's designated contact information, including name, mailing address, phone number, fax number, and email address.

3. a. Within five business days of receiving a Medicaid provider's request for review pursuant to this subsection, the managed care organization shall do all of the following:

(1) Confirm to the Medicaid provider's designated contact, in writing, that the managed care organization has received the request for review.

(2) Notify the department of the Medicaid provider's request for review.

(3) Notify the affected Medicaid member of the Medicaid provider's request for review, if the review is related to the denial of a service.

b. If the managed care organization fails to satisfy the requirements of this subsection 3, the Medicaid provider shall automatically prevail in the review.

4. a. Within fifteen calendar days of receiving a Medicaid provider's request for external independent third-party review, the managed care organization shall do all of the following:

(1) Submit to the department all documentation submitted by the Medicaid provider in the course of the managed care organization's internal appeal process.

(2) Provide the managed care organization's designated contact information, including name, mailing address, phone number, fax number, and email address.

b. If a managed care organization fails to satisfy the requirements of this subsection 4, the Medicaid provider shall automatically prevail in the review.

5. An external independent third-party review shall automatically extend the deadline to file an appeal for a contested case hearing under chapter 17A, pending the outcome of the external independent third-party review, until thirty calendar days following receipt of the review decision by the Medicaid provider.

6. Upon receiving notification of a request for external independent third-party review, the department shall do all of the following:

a. Assign the review to an external independent third-party reviewer.

b. Notify the managed care organization of the identity of the external independent third-party reviewer.

c. Notify the Medicaid provider's designated contact of the identity of the external independent third-party reviewer.

7. The department shall deny a request for an external independent third-party review if the requesting Medicaid provider fails to exhaust the managed care organization's internal appeals process or fails to submit a timely request for an external independent third-party review pursuant to this subsection.

8. a. Multiple appeals through the external independent third-party review process regarding the same Medicaid member, a common question of fact, or interpretation of common applicable regulations or reimbursement requirements may be combined and determined in one action upon request of a party in accordance with rules and regulations adopted by the department.

b. The Medicaid provider that initiated a request for an external independent third-party review, or one or more other Medicaid providers, may add claims to such an existing external independent third-party review following exhaustion of any applicable managed care organization internal appeals process, if the claims involve a common question of fact or interpretation of common applicable regulations or reimbursement requirements.

9. Documentation reviewed by the external independent third-party reviewer shall be limited to documentation submitted pursuant to subsection 4.

10. An external independent third-party reviewer shall do all of the following:

a. Conduct an external independent third-party review of any claim submitted to the reviewer pursuant to this subsection.

b. Within thirty calendar days from receiving the request for review from the department and the documentation submitted pursuant to subsection 4, issue the reviewer's final decision to the Medicaid provider's designated contact, the managed care organization's designated contact, the department, and the affected Medicaid member if the decision involves a denial

of service. The reviewer may extend the time to issue a final decision by fourteen calendar days upon agreement of all parties to the review.

ll. The department shall enter into a contract with an independent review organization that does not have a conflict of interest with the department or any managed care organization to conduct the independent third-party reviews under this section.

a. A party, including the affected Medicaid member or Medicaid provider, may appeal a final decision of the external independent third-party reviewer in a contested case proceeding in accordance with chapter 17A within thirty calendar days from receiving the final decision. A final decision in a contested case proceeding is subject to judicial review.

b. The final decision of any external independent third-party review conducted pursuant to this subsection shall also direct the nonprevailing party to pay an amount equal to the costs of the review to the external independent third-party reviewer. Any payment ordered pursuant to this subsection shall be stayed pending any appeal of the review. If the final outcome of any appeal is to reverse the decision of the external independent third-party review, the nonprevailing party shall pay the costs of the review to the external independent third-party reviewer within forty-five calendar days of entry of the final order.

DIVISION ___

PUBLIC ASSISTANCE PROGRAM ACCOUNTABILITY —— MEDICAID PROGRAM CONSUMER PROTECTION

Sec. ___. NEW SECTION. **2C.6A Assistant for Medicaid program.**

1. The ombudsman shall appoint an assistant who shall be primarily responsible for investigating complaints relating to the Medicaid program, including both Medicaid fee-for-service and managed care payment and delivery systems, and all Medicaid populations including the long-term services and supports

population.

2. The ombudsman shall provide assistance and advocacy services to Medicaid recipients and the families or legal representatives of Medicaid recipients. Such assistance and advocacy shall include but is not limited to all of the following:

a. Assisting recipients in understanding the services, coverage, and access provisions and their rights under the Medicaid program.

b. Developing procedures for the tracking and reporting of the outcomes of individual requests for assistance, the procedures available for obtaining services, and other aspects of the services provided to Medicaid recipients.

c. Providing advice and assistance relating to the preparation and filing of complaints, grievances, and appeals of complaints or grievances, including through processes available under managed care plans and the state appeals process under the Medicaid program.

3. The ombudsman shall adopt rules to administer this section.

4. The ombudsman shall publish special reports and investigative reports as deemed necessary and shall include findings and recommendations related to the assistance and advocacy provided under this section in the ombudsman's annual report.

Sec. ___. REPEAL. Section 231.44, Code 2019, is repealed.>

9. By renumbering as necessary.

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LIZ MATHIS

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AMANDA RAGAN